Dept. Health, Ed., & Welfare U. S. Public Health Service

FORM U. S. 300 Rev. 1-57

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

42144 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10784

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis, Mo. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 14 Jewish Hospital — Length of stay in 1b: 23 9 0
d. STREET ADDRESS (If outside, give location): 1204 Park Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First BRENDA. Middle — Last Jacobson

4. DATE OF DEATH: Month NOV Day 12 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 25, 1957 ✓

9. AGE (In years last birthday): IF UNDER 1 YEAR Months 2 Days — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Jesse Jacobson

13b. MOTHER'S MAIDEN NAME: Emily Shepard

14. NAME OF HUSBAND OR WIFE: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Jesse Jacobson — Address: 1204 Park Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diarrhea — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs —
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 571.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 11, 1957 to Nov 12, 1957 and last saw her alive on Nov 12 1957
Death occurred at 4 Am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Seymour M Schlang M.D.

22b. ADDRESS: 7247 Delmar

22c. DATE SIGNED: 11-12-57

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 11-14-57

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): Carter, Wisconsin

24. FUNERAL DIRECTOR ADDRESS: Croghan Funeral Home 7146 Manchester

25. DATE RECD. BY LOCAL REG.: NOV 12 57

26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Conforming the medical certification in the specific manner required by 193.140 RSMo 1949.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.